STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to protect the corridor openings. The finding included: Observation on 12/2/13 at 9:45 AM revealed the supply closet in the 400 hall did not have a door. The closet contained a trash bin, soiled linen bin, and biohazard bin. This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 12/2/13.	K 018	**K 018 NFPA Life Safety Code Standard** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** On 12/02/13, the trash, soiled-linen and Biohazard bins were permanently removed from the 400 hall storage closet and placed in the 400 hall shower room, on storage side. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected The Maintenance Director will monitor the 400 hall closet weekly for proper storage. **What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** The Maintenance Director will be responsible for monitoring 400 hall closet and add 400 hall closet to weekly check list. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur**	12/2/13
K 066	NFPA 101 LIFE SAFETY CODE STANDARD	K 066		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mich Ward, CEO | TITLE | (X6) DATE: 12/20/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

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K 018			The Maintenance Director will bring 400 hall check list to the Quality Assurance Performance Improvement Committee meeting monthly, for (3) months and then PRN, if needed. The Quality Assurance Performance Improvement Committee members are the Administrator, Director of Nursing, Staff Development Coordinator, Social Services Director, Maintenance Director, Business Office Manager, Dietary Manager and the Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066 SS=D	Continued From page 1 Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to comply with the smoking regulations. The finding included: Observation on 12/2/13 at 9:47 AM revealed there were no metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is	K 066	**K 066 NFPA Life Safety Code Standard** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** On 12/02/13, a self-closing metal container approved for ashtray empting was purchased and put into use in the facility smoking area. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. The Maintenance Director will monitor proper placement of the self-closing metal container in facility smoking area weekly. **What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** On 12/4/13, the Maintenance Director revised Maintenance Facility Rounds Checklist to reflect the proper location of the self-closing metal container for ashtray waste storage.	12/2/13 12/4/13

Michael Ward, CEO 12/20/13

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K 066	Continued From page 2 permitted. This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 12/2/13.	K 066	**How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur** The Maintenance Director will bring monitor check list to the Quality Assurance Performance Improvement Committee meeting monthly, for (3) months and then PRN, if needed. The Quality Assurance Performance Improvement Committee members are the Administrator, Director of Nursing, Staff Development Coordinator, Social Services director, Maintenance Director, Business Office Manager, Dietary Manager and the Medical Director.	

Mark Ward, CEO 12/20/13

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